Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Victory Medical Center

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-1957-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the Texas State Fee Schedule, there are two ways an out-patient claim can be paid. First would be 200% of the OPPS State Fee Schedule. If there were no implants involved, or we didn't want separate reimbursement for our implants. …With the total payment of $7,856.74 that we have received from Texas Mutual, we calculate we are still entitled to an additional payment of $4,002.08 based on how we requested this claim be processed."

Amount in Dispute: $4,047.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor states it is owed additional reimbursement for services provided with codes 63688 and 63662. The requestor demands additional reimbursement of $4,047.70 but has not shown why that amount plus the Texas Mutual's original payment amount of $7,811.14, is fair and reasonable."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 19 – 21, 2014	Outpatient Hospital Services	$4,407.70	$758.51

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 631 – PT OT or SP code present without required non payable code
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
   - 193 – Original payment decision is being maintained

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 85610, date of service August 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80053, date of service August 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80053, date of service August 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85025 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85730, date of service August 19, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 63662 has a status indicator of Q2, which denotes T-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicator T that are billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date.
   - Procedure code 63688 has a status indicator of Q2, which denotes T-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicator T that are billed for the same date of service. If there are multiple STVX and/or T packaged codes on a specific date and no service with which the codes would be packaged on the same date, the code assigned to the APC with the highest payment will be paid. These services are classified under APC 0688, which, per OPPS Addendum A, has a payment rate of $2,222.17. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,333.30. This amount multiplied by the annual wage index for this location of 0.9884 yields an adjusted labor-related amount of $1,317.83. The non-labor related portion is 40% of the APC rate or $888.87. The sum of the labor and non-labor related amounts is $2,206.70. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2014 Default CCR as 0.197. This ratio multiplied by the billed charge of $6,058.61 yields a cost of

$1,193.55. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $2,206.70 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $6,870.03. The allocated portion of packaged costs is $6,870.03. This amount added to the service cost yields a total cost of $8,063.58. The cost of these services exceeds the annual fixed-dollar threshold of $2,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,201.85. 50% of this amount is $2,100.93. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $4,307.63. This amount multiplied by 200% yields a MAR of $8,615.25.

- For procedure code 97116. The Carrier denied the service in dispute as 631 – "PT OT or SP code present without required non payable code." Per Centers for Medicare and Medicaid Services MedLearn Matters Article, Number: SE1307: "Effective January 1, 2013, claims for outpatient therapy services are required to include non-payable G-codes and modifiers, which describe a beneficiary's functional limitation and severity level, at specified intervals during the episode of care." No non-payable G code or modifier was found. The Carrier's denial is supported.
- For procedure code 97001. The Carrier denied the service in dispute as 631 – "PT OT or SP code present without required non payable code." Per Centers for Medicare and Medicaid Services MedLearn Matters Article, Number: SE1307: "Effective January 1, 2013, claims for outpatient therapy services are required to include non-payable G-codes and modifiers, which describe a beneficiary's functional limitation and severity level, at specified intervals during the episode of care." No non-payable G code or modifier was found. The Carrier's denial is supported.
- Procedure code J2795 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3360 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0330 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $8,615.25. This amount less the amount previously paid by the insurance carrier of $7,856.74 leaves an amount due to the requestor of $758.51. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $758.51.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $758.51, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.